State of Nevada
Office of Health Information Technology &
Division of Health Care Financing and Policy
HIT & HIE Assessment
Survey Glossary of Terms[1]

Active Medication Allergy List: A list of a patient's known or reported allergies to medications especially any that may impact current health status. The Meaningful Use criteria measurement is at least 80 percent of all unique patients seen by the Eligible Provider (EP) have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data.

Active Medication List: A list of a patient's known or reported list of medications (including over-the-counter medications) especially any that may impact current health status. The Meaningful Use criteria measurement is at least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.

After-visit Clinical Summaries: Patient information containing updated medication lists, lab and test orders, procedures, and instructions based on clinical discussions taking place during a patient visit.

Care Plans: Written documents for certain chronic conditions requiring advanced management. Care plans are developed with the patient and guide care management by outlining risks, goals, prevention, and actions for treatment (e.g. an asthma action plan).

Certification Commission for Healthcare Information Technology (**CCHIT):** A voluntary, private-sector organization launched in 2004 to certify health information technology (HIT) products such as electronic health records and the networks over which they interoperate. See www.cchit.org.

Clinical Data Repository (CDR): A clinical data repository (CDR) is a real-time database that consolidates data from a variety of clinical sources to present a unified view of a single patient. It is optimized to allow clinicians to retrieve data for a single patient rather than to identify a population of patients with common characteristics or to facilitate the

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[1] Sources referenced include:

- State Health Information Exchange Cooperative Agreement Program, Funding Opportunity Announcement, Office of the National Coordinator for Health Information Technology Department of Health and Human Services, 2009.
- The National Alliance for Health Information Technology Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms, April 28, 2008
- Healthcare Information and Management Systems Society (HIMSS) Educational Tools http://www.himss.org/ASP/topics_FocusDynamic.asp?faid=141, accessed April 28, 2010.
- State HIE Toolkit: http://statehieresources.org/the-toolkit/terms-acronyms/
- Health Information Technology Toolkit Glossary from the Rural Health Resource Center: http://www.ruralcenter.org/?id=res_hit, accessed April 28, 2010
- State of Minnesota Health Information Technology (HIT) Ambulatory Clinic Survey definitions

management of a specific clinical department. Typical data types which are often found within a CDR include: clinical laboratory test results, patient demographics, pharmacy information, radiology reports and images, pathology reports, hospital admission/discharge/transfer dates, ICD-9 codes, discharge summaries, and progress notes.[2]

Clinical Data Warehouse (CDW): Similar to a CDR, but with more sophisticated data analysis and querying capabilities.

Clinical Decision Support (CDS): Clinical decision support systems (CDSS) assist the physician in applying new information to patient care and help to prevent medical errors and improve patient safety. Many of these systems include computer-based programs that analyze information entered by the physician. Also see Clinical Decision Support Tools below.

Clinical Decision Support Tools: Clinical decision support tools are health information technology functions that build on the foundation of an electronic health record (EHR) to provide persons involved in patient care with general and patient-specific information that is intelligently filtered and organized to enhance patient health. Also see Clinical Decision Support (CDS) above.

Computerized Provider Order Entry (CPOE): A computer application that allows a physician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer has the ability to compare the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.

Electronic Health Record (EHR): An electronic record of health-related information regarding an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization. For purposes of this survey, this definition is the same as an Electronic Medical Record (EMR).

Electronic Health Record (EHR) Certification for meaningful use: The certification of a provider's EHR by CCHIT according to meaningful use.

Electronic Medical Record (EMR): An electronic record of health-related information regarding an individual that conforms to nationally recognized interoperability standards and that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization. For purposes of this survey, this definition is the same as an Electronic Health Record (EHR).

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[2] Taken from "Building and Using a Clinical Data Repository" last accessed April 28, 2010 at http://www.informatics-review.com/thoughts/cdr.html

Eligible Professionals (EPs): In the Medicaid Incentive Program, EPs "are physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants practicing predominantly in a Federally Qualified Health Center or Rural Health Clinic (FQHC/RHC) that is directed by a physician assistant." A Medicare Incentive Program EP "is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, who is legally authorized to practice under state law. A qualifying EP is one who demonstrates meaningful use for the EHR reporting period. Hospital-based EPs who furnish substantially all their services in a "hospital setting" are not eligible for incentive payments."[3]

Eligible Hospitals (EHs): In the Medicaid Incentive Program, eligible hospitals "that may participate...are acute care hospitals and children's hospitals."

E-Prescribing/ERx: Technology where physicians use handheld or personal computer devices to review drug information and then transmit prescriptions to a printer, electronic health record, or pharmacy. Software for E-Prescribing can be integrated into existing systems to allow physician access to patient-specific information in order to screen for drug interactions.

Health Information Exchange (HIE): The electronic movement of health-related information among organizations according to nationally recognized standards. For the purposes of this survey, organization is synonymous with healthcare providers, public health agencies, payers and entities offering patient engagement services (such as Patient Health Records).

Health Insurance Portability and Accountability Act (HIPAA)). A law passed by the U.S. Congress in 1996 (Public Law 104-191) that included provisions that required Health and Human Services (HHS) to adopt national standards for electronic healthcare transactions. HIPAA includes provisions that require doctors, hospitals and others protect the privacy of patients' health care information.

Health Information Organization (HIO): An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Health Information Technology (HIT): The organization, analysis and generation of health data to treat patients and for insurance and other reimbursement, or for planning, quality assessment, research, and legal purposes.

Interoperability: The ability of two or more systems or components to exchange

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[3] The Eligible Professional and the Eligible Hospital definition taken from Federal Register, DHHS Centers for Medicare & Medicaid Services 42 CFR Parts 412, et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule, Part II.

information and to use the information that has been exchanged. Typically, interoperability is understood to have three components: technical, semantic, and process. See http://www.hl7.org/ehr/downloads/index_2007.asp

Master Patient Indexing (MPI): MPI is a software database program that collects a patient's various provider identification numbers and keeps them under a single, community or enterprise-wide identification number.

Meaningful Use: The American Recovery and Reinvestment Act of 2009 (Recovery Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to provide reimbursement incentives for eligible professionals and hospitals who are successful in becoming "meaningful users" of certified electronic health record (EHR) technology. The Medicare EHR incentive program will provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHR technology. The Medicaid EHR incentive program will provide incentive payments to eligible professionals and hospitals for efforts to adopt, implement, or upgrade certified EHR technology or for meaningful use in the first year of their participation in the program and for demonstrating meaningful use during each of five subsequent years.[4]

Patient Problem List: A list of a patient's diagnoses and conditions - including past conditions that may impact current health status.

Personal Health Record (PHR): An electronic record of health-related information regarding an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

Regional Health Information Organization (RHIO): A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

Structured and Reportable Data: Test results that are entered into EHR systems in a digital or coded format - such as numbers or standard text values (e.g. "positive" or "negative").

Telemedicine: The use of medical information that is exchanged from external health care organizations via electronic communication.

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[4] From the US Department of Health and Human Services website accessed April 28, 2010: http://healthit.hhs.gov/portal/server.pt?open=512&objID=1325&parentname=CommunityPage&parentid=1&mode=2#Overview